North Carolina
State Consumer & Family Advisory Committee
(SCFAC)

Fall/Winter 2011

Email SCFAC
State.CFAC@dhhs.nc.gov

Peer Support Specialists

Behavioral Healthcare Resource Program (BHRP) has defined the role of a Peer Support Specialist as *an active skill that evolves from individuals who have been diagnosed with mental illness and/or substance abuse challenges, who have begun the journey of recovery, and who have a passion to give back and help others navigate the recovery process*. Peer Support Specialists are not therapists, social workers, or psychiatrists, however, through required state approved Peer Support Specialists Training, they have the knowledge and skills to provide peer support.

Vision for Peer Support in North Carolina

To develop a qualified Peer Support Specialist workforce that has the support, access, credibility, competency, respect and the valued role within the mental health and substance abuse service delivery system to positively impact the lives of individuals experiencing mental health and addiction challenges. This is accomplished through the NC Certified Peer Support Specialist Program and can be reviewed at http://pss-sowo.unc.edu

Rosemary Weaver, SCFAC Chair

After my first year as SCFAC Chair, I can attest to the fact that this job is daunting- especially since budget issues have dictated a bi-monthly meeting schedule and as new initiatives are rapidly rolled out by DHHS. Much of the work as a committee is done behind the scenes. Phone calls, emails, and other communication occurs almost daily. Many of the members and I have full or part time jobs and juggle schedules to meet the demands. The same holds true for local CFAC members. I want to express my heartfelt appreciation to the SCFAC members who have assisted in carrying out our statutory duties, as well as the consumers and family members across the state and the staff support provided by DHHS. I couldn't do this job without all of you.

DHHS has been moving in an entirely different direction this year and doing it rather quickly. A lot of you had concerns and questions regarding LME mergers and statewide waiver implementation. The SCFAC has done its best to remain current and address areas of concern. The most important issue we need to focus on in the coming months is the changes that may be made to Statute 122c. In addition to the governance of the SCFAC and LCFACs, this statute encompasses many areas: human rights, consumer advocacy, involuntary commitments, psychiatric advance directives, the structure of the LME boards and directors, the Appeals Panel, licensure and operation of state facilities, the powers and duties of the Mental Health Commission, and the powers of the Secretary, etc.

The General Assembly and DHHS will be looking at all sections of the statute and any changes made will affect us and our loved ones for many years to come. I encourage you to contact your senators and representatives, work with your LME board, partner with stakeholder groups, work with the Consumer Empowerment Team members, and get involved as much as possible in shaping the future of MH/DD/SA Services.

The 10 Fundamental Components of Recovery

"Recovery must be the common, recognized outcome of the services we support," SAMHSA Administrator Charles Curie said. "This consensus statement on mental health recovery provides essential guidance that helps us move towards operationalizing recovery from a public policy and public financing standpoint. Individuals, families, communities, providers, organizations, and systems can use these principles to build resilience and facilitate recovery."

- ***Self-Direction***: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- ***Individualized and Person-Centered***: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- ***Empowerment:*** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- ***Holistic:*** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- ***Non-Linear***: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- ***Strengths-Based***: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- ***Peer Support***: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- ***Respect:*** Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

The 10 Fundamental Components of Recovery CONTINUED…

- **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The National Consensus Statement on Mental Health Recovery is available at SAMHSA's Clearinghouse 877-SAMHSA7 (726-4727).

National Peer Support Specialists

The number of Peer Support Specialists (PSS) is on the rise across the United States and foreign countries. PSS themselves have come full-circle and know that persons with mental illness can recover and live productive, meaningful lives. PSS work on the front line to battle stigma, guilt and shame and are working with clients to "climb the recovery mountain together."

The **National Association of Peer Support Specialists (NAPS)** was selected to participate in the *Recovery to Practice* initiative, a five year project supported by SAMHSA. On March 1, 2010, five mental health disciplines were awarded contracts to enhance recovery education by SAMHSA: social workers, psychiatrists, psychiatric nurses, psychologists and peer specialists.

The first year of the *Recovery to Practice (RTP)* project included the creation of a situational analysis based on efforts to understand the current status of the professions, identifying and marshalling recovery resources and identifying recovery knowledge gaps with the goal of creating a recovery curriculum for each discipline. A copy of the Recovery to Practice Situational Analysis can be downloaded for free at www.naops.org. For additional information on the National Association of Peer Support Specialists, contact Gladys Christian, NAPS President, at gladys@naops.org and/or call (336) 422-9086.

Statewide 1915 b/c Waiver

The Department of Health and Human Services is proceeding with plans to implement the 1915 b/c Waiver statewide in North Carolina by January 1, 2013. In April of this year, the Department issued its final Request for Application (RFA) for the expansion of the Waiver. During this process, three more LME's were chosen to begin the implementation of the Waiver; the remaining four either have a corrective action or must resubmit their applications.

The LMEs in the process of Waiver Implementation are: Western Highlands, Mecklenburg, ECBH, Sandhills, Eastpointe with SER and Beacon, Pathways with Crossroads and Mental Health Partners, Durham Center in collaboration with Cumberland and Johnston, and Smokey Mountain Center. PBH will also be merging with Alamance Caswell, Five County and OPC. All of these LMEs will begin having monthly implementation meetings with the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. These meetings will monitor the implementation of the waiver and target key milestones that must be achieved to be ready to operationalize the waiver by January 2013. Each LME has a different target start date that will achieve the Department's goal of being fully operational statewide by January 2013. The remaining three LMEs have been working on the process during the months of September and October.

Consumer Involvement

A team of seven consumers and family members representing mental health, developmental disabilities and substance abuse service recipients have been an integral part of the RFA process for the 1915 b/c waiver implementation. These individuals come from all regions of the state and have participated in desk and site reviews as applications have been considered for acceptance. They will be part of the ongoing monitoring process to ensure that consumers and families are being included by the LME/MCOs in the design and implementation of the 1915 b/c waivers. The Department of Health and Human Services considers consumer, family and stakeholder input crucial to the success of this transition and will continue to encourage and monitor their involvement**.**

SCFAC MEMBER SPOTLIGHT

Paul Russ, a member of the SCFAC and the Southeastern Regional CFAC, was the recipient of the CFAC Leadership Award given by the NC Council on Community Programs at their Spring Policy Forum on May 23, 2011. Paul was recognized for his leadership role in the Southeastern Regional CFAC. As a parent of a special needs child, he knows the importance of consumer and family involvement at all levels of planning and policy making. Paul is one of the task team chairs on the SCFAC. His task team is charged with reviewing and commenting on the state plan. The SCFAC chair also appointed him to serve on the DMH Waiver Leadership Team.

At the local level, Paul is chair of the Southeastern Regional CFAC. He is also a member of the LME Board of Directors and has been involved in many committees including client rights, accreditation, management, training and IPRS workgroup.

In spite of all he does for consumers and family members, Paul is a very humble man. He does not strive to seek recognition; rather he strives for excellence in everything he does. The SCFAC officially recognizes his achievements and thanks Paul for his contributions at both the state and local level.

The Asperger Connection School, which recently opened in Pikeville, provides the continuum of individual education for children with High Functioning Autism/Asperger. Nancy Black, a former SCFAC member, is the founder of the school and also serves as its executive director. Its mission is to work in partnership with parents and the community to encourage students to reach their unique and full potential by developing critical thinking skills, social sills, and self-confidence. Each staff member has particular experience and training with Asperger as a family member or a person who has Asperger.

The Asperger Connection School focuses on building key social strengths and strong personal organizational tools. Some of the strategies include positive reinforcement, individual education and social skill training, training modules for parents, use of evidence based educational programs, and digital based technology. The student/teach ratio is 5 to 1.

For further information, contact the school directly or visit the school's web site:

503 Glendale Drive
Pikeville, NC
(919) 920-5799
www.theaspergerconnectionschool.org

Centers For Independent Living

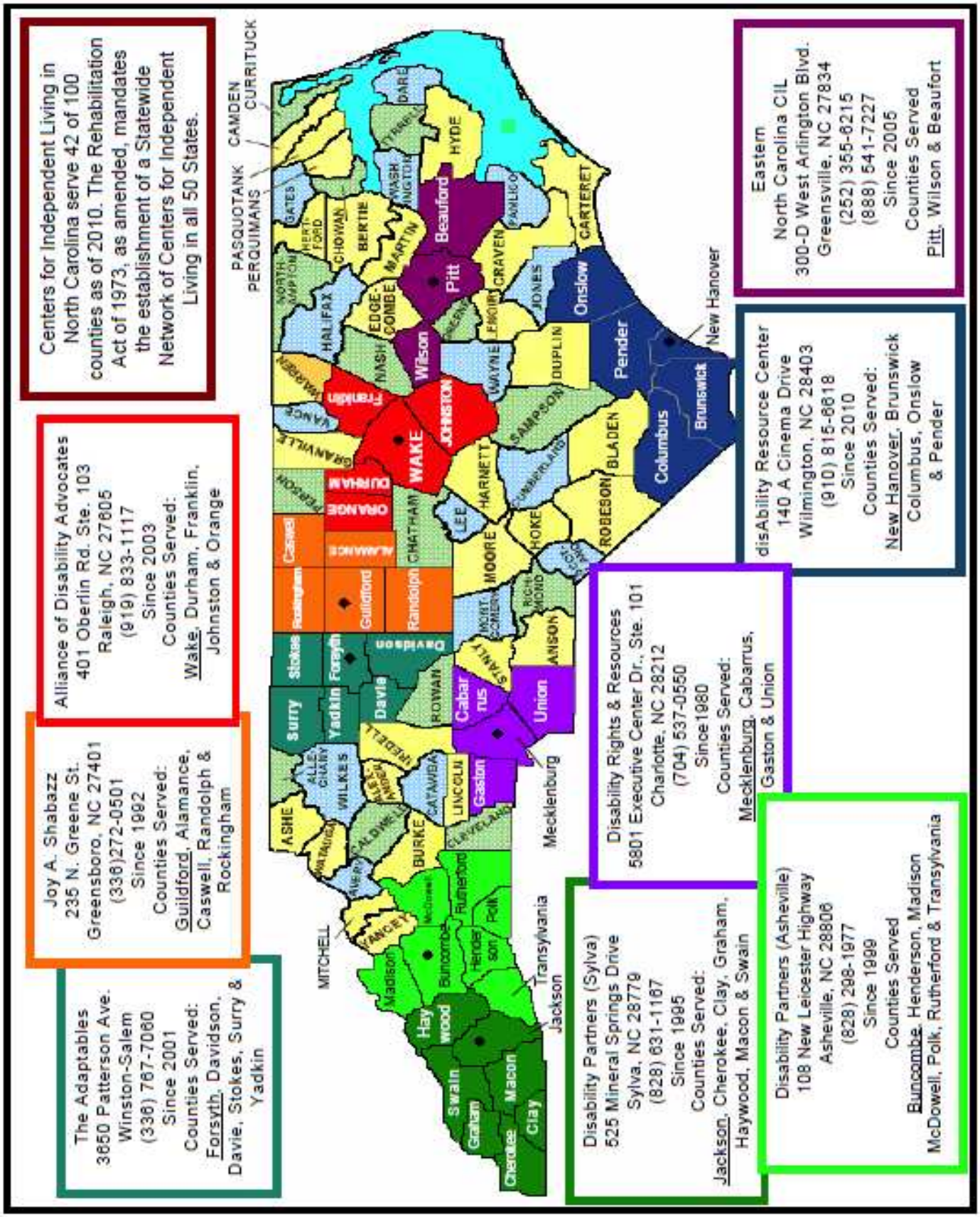
Centers for Independent Living (CIL) are private, non-profit, consumer controlled community based organizations providing services by and for persons with all types of disabilities. The Rehabilitation Act of 1973, as amended, mandated the establishment of a state wide network of CILs in all 50 states. The goals of CILs are to maintain the civil rights of the persons they service allowing them to control and choose their services, to have the freedom to make their own choices, and to participate fully in the community of their choice.

Most CILs provide the following services: Advocacy, Peer Counseling, Information and Referral, and Independent Living Skills Training. Some CILs in North Carolina so provide the service of transitioning consumers from institutional living to community living. Peer Support is an integral part of Independent Living, so the majority of the staff and board of directors of every CIL are people with disabilities. CILs are committed to treating people with disabilities with respect and using and promoting "person first" language.

There are eight CILs that serve a total of 39 counties. They are located in Asheville, Charlotte, Greensboro, Greenville, Raleigh, Sylva, Wilmington, and Winston-Salem. **All services provided by CILs are free** to consumers. CILs do not receive Medicaid or IPRS funds, nor do they bill any insurance companies. They are funded through the Department of Education of the U.S. Government by recurring grants. For further information, contact the NC Statewide Independent Living Council at:

401 Berlin Road, Suite 115
Raleigh, NC 27605
(919) 832-3636
Toll Free (888) 762-7452 (888-7NCSILC)
www.ncsilc.org

Centers for Independent Living Map on page 6



Centers For Independent Living (CILs) across North Carolina

Family Partners

Alamance County received a **SAMHSA** System of Care grant two years ago that serves children from birth to 5 years old called Alamance Alliance. Alamance saw the need for early intervention for children with or at risk of social/emotional or mental health challenges. When the grant was written, the need for family support (same as peer support in the adult world) was seen as a need. October 1, 2011 started year 3 for the grant. The grant included having Family Partners trained and providing support to families. NC Families United provides the Family Partners for the grant. There are currently six Family Partners (one who is Spanish speaking) and a Family Partner Coordinator. In 17 months, they have enrolled approximately 139 children and of those, 119 have Family Partners. Information can be found on the website: www.alamancesoc.org. Alamance Alliance has been training community partners and families on issues related to children at risk. Their goal is to make sure families are safe, healthy and together.

A Family Partner is defined as *a caregiver/parent of someone who has received services and therefore has firsthand experience within the child and family system, or who has gone through the system themselves*. This definition has been approved by NC Families United, and is endorsed by the NC Collaborative for Children and Families.

Family Partners are required to have 80 hours of training. A few of the required trainings are: ***Family Partner Training***, (similar to Peer Support training), ***Motivational Interviewing***, ***Child and Family Team Training from The Families Perspective, A Cross System Approach*** and ***W.R.A.P*** (Wellness Recovery Action Planning). Family Partners work with families of children or youth from birth to 18 who have social/emotional challenges or mental illness. Family Partners in NC is currently working to be certified nationally through the National Federation of Families for Children's Mental Health.

In North Carolina, we have Family Partners in many parts of the state. Family Partners work with families, providing emotional support and encouragement to the parents. Having gone through the system themselves, Family Partners know first hand how hard raising a child with challenges can be. Some of what Family Partners do is:

- LISTEN to a parent and provide support and encouragement
- Provide care coordination, linking families to resources, such as mental health providers, DSS, Public Health, community organizations or Faith Based organizations
- Attend meetings with families as requested
- Assist families in advocating for themselves
- Create an understanding for families of how child serving agencies work
- Facilitate child and family teams
- Develop a Futures Map with the family that is used to develop goals

The goals for Family Partners in North Carolina are:

To teach and mentor other parents to be effective advocates for their own family;
To increase the voice of parents and youth;
To build partnerships between agencies and parents; and,
To promote family-driven and youth guided services.

If you would like future information on Family Partners, or information on National Certification for Family Partners please contact: Gail Cormier, Executive Director, NC Families United at 919-880-1868, or Libby Jones, Family Support Director, NC Families United at 336-380-7274 www.ncfamiliesunited.org

State Consumer and Family Advisory Committee Members

Rosemary Weaver, Chair	**Libby Jones, Vice Chair**
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Laura Keeney	**Paul Russ**
Marc Jacques	**Christine Tolbert**
	Doug Wright

2011-2012 Meetings
Are held at the
Clarion Hotel State Capital
320 Hillsborough Street
Raleigh, NC 27603

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November 10, 2011
January 12, 2012
March 8, 2012
May 10, 2012
July 12, 2012
September 13, 2012
November 8, 2012

nc department of health and human services

RESOURCES

Housing in North Carolina

The NC Coalition has lots of great resources and tips on affordable housing in North Carolina. To utilize their free housing locator go to www.nchousingsearch.org. They also have a toll-free number (877-428-8844) you can call.

The following activities are the key focus of the NC Coalition:

- **Resource and Referral**
- **Technical Assistance/Outreach**
- **Advocacy**
- **Clearinghouse for Data, Statistics, Best Practices and Research**

Don't miss ***Housing Works***, the 2011 North Carolina Affordable Housing Conference November 1-2, 2011 at the Raleigh Convention Center, Downtown Raleigh. Please visit their website at www.nchousing.org

State CFAC Representation as of August 17, 2011